Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Washington, DC VA Medical Center

Report No. 02-02172-129

July 14, 2003

VA Office of Inspector General
Washington, DC 20420

Contents

Executive Summary

Introduction

During the week of July 15-19, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Washington, DC Veterans Affairs Medical Center (DCVAMC). The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 370 employees.

Results of Review

DCVAMC patient care and performance improvement/quality management (PI/QM) activities reviewed were generally effective. DCVAMC management actively supported high-quality patient care and performance improvement. The PI/QM program was comprehensive and provided effective oversight of the quality of care. Financial and administrative activities were generally operating satisfactorily and management controls were generally effective. The DCVAMC needed to:

- Strengthen management controls to avoid potential conflicts of interest, and improve compliance with contract administration requirements.
- Strengthen Government Purchase Card Program controls.
- Improve controls over timely billing to third-party insurers.
- Improve controlled substances inspection procedures.
- Strengthen controls over vendor representative visits.
- Improve controls over supply inventory management and reduce excess inventories.
- Improve controls over reports of surveys.
- Enhance automated information systems security awareness training.
- Improve timekeeper desk audits.
- Improve the environment of care.

VISN 5 Director and DCVAMC Director Comments

The VISN 5 Director and the DCVAMC Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix B pages 20 through 26, for the full text of the Directors' comments). We will follow up on planned actions until they are completed.

RICHARD J. GRIFFIN
Inspector General

Introduction

VA Medical Center Profile

Organization. The DCVAMC is a tertiary care hospital that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at community-based clinics located in Greenbelt, MD, Alexandria, VA, and Southeast Washington, DC. The DCVAMC is part of Veterans Integrated Service Network (VISN) 5 and serves a population of about 349,326 veterans in a primary service area that includes metropolitan Washington, DC and selected counties in Maryland and Virginia.

Programs. The DCVAMC provides medical, surgical, mental health, geriatric, and rehabilitation services. The DCVAMC has 166 acute inpatient beds and 120 nursing home beds, and operates several regional referral and treatment programs including cardiac surgery. The DCVAMC has sharing agreements with Walter Reed Army Medical Center, St. Elizabeth Hospital, and the Washington Hospital Center.

Affiliations and Research. The DCVAMC is affiliated with the Howard University School of Medicine, the Georgetown University School of Medicine, and the George Washington University School of Medicine and Health Sciences, and supports medical resident positions in medicine, surgery, neurology, mental health, pathology, and radiology. In Fiscal Year (FY) 2001, the DCVAMC had 97 active research projects with funding of $2,366,217 from Central Office, $1,607,927 from other federal agencies, and $2,500,000 from the Institute for Clinical Research, Inc. Important areas of research included: Alzheimer's disease, cardiology, cell biology, diabetes, digestive diseases, endocrinology, genetics, hypertension, AIDS and other infectious diseases, liver diseases (including hepatitis), nephrology, neuroscience (including schizophrenia), oncology, pain management, pneumonia, psychiatry, tuberculosis and other pulmonary diseases, virology, and special studies related to Gulf War-related illnesses.

Resources. In FY 2001, DCVAMC medical care expenditures totaled $182,048,734, excluding capital expenditures. The FY 2002 appropriated budget was $180,612,985 plus a projected $10,884,036 in the medical cost collection fund (MCCF) for a total available budget of $191,497,021. As of June 1, 2002, staffing was 1,620 full-time equivalent employees (FTEE), including 141 physician and 567 nursing FTEE.

Workload. In FY 2001, the DCVAMC treated 38,962 unique patients, an 8-percent increase over FY 2000. The FY 2001 inpatient workload totaled 6,490 discharges, and the average daily census, including nursing home patients, was 223. The outpatient workload was 227,835 visits.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employees' understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Accounts receivable	Part-time physician timekeeping
Acute medical-surgical units	PI/QM Programs
Clinical services contracts	Rehabilitation and extended care
Controlled substances accountability	Reports of surveys
Government Purchase Card Program	Supply inventory management
Homemaker/Home Health Aid Program	Vendor representative visits
Information technology security	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. Questionnaires were sent to 425 DCVAMC employees, 119 of whom completed and returned the questionnaires. The survey response was largely positive indicating that high-quality care is the first priority of the medical center, that patients are involved in their care through education regarding their diagnoses, medications, and treatments, and that security of patient information is maintained. While a significant majority of the respondents discussed issues related to staffing, support services, and adverse events, due to the low questionnaire response rate (28 percent), we did not make any recommendations or suggestions. We provided the DCVAMC Director with copies of the responses for his information. We also interviewed 57 patients during the review. The patient survey indicated a high level of satisfaction with treatments and services.

During the review, we presented fraud and integrity awareness briefings to 370 DCVAMC employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered DCVAMC operations for FY 2001 and FY 2002 through June 2002, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by the DCVAMC and VISN 5 management until corrective actions are completed.

Results of Review

Organizational Strengths

The DCVAMC Code "Blu" (Cardiac Arrest) Committee Was A Model of Excellence and Innovation. Under the coordination of PI/QM employees and chairmanship of the Medical Intensive Care Unit Medical Director, the DCVAMC Code "Blu" Committee's operations were innovative, comprehensive, and effective. Examples of innovations that the Committee implemented to improve the facility-wide Code "Blu" response are: installing automatic external defibrillators in selected public areas to provide timely emergency treatment; and providing carbon dioxide detectors on Code "Blu" carts to quickly assess proper placement of endotracheal tubes and airway effectiveness during cardio-pulmonary resuscitation (CPR). The Committee also comprehensively tracked and analyzed various aspects of the Code "Blu" program including CPR outcomes (by location, patient demographics, diagnoses, and dates and times of day), response times of code team members, quality of employees' performances during CPR and intubation, equipment/system problems, and training requirements. The Committee minutes displayed results and analyses of these data in a comprehensive and easy to read array of charts and graphs. The Committee sent detailed follow-up letters to appropriate services to encourage timely resolution of identified issues.

The PI/QM Program Was Comprehensive and Provided Effective Oversight. The DCVAMC had an effective PI/QM Program to monitor the quality of care, patient safety management, and utilization review. Comprehensive PI/QM monitors were in place to improve patient care. PI/QM findings were properly analyzed to detect trends, and actions were taken to address individual issues. Administrative investigations, focused and peer reviews, and root-cause analyses were conducted properly, and corrective actions were implemented. Clinical managers had a structured and comprehensive system for monitoring attending physicians' supervision of medical residents. The DCVAMC had a mechanism to provide uniform physician profile records to document credentialing and privileging (C&P) decisions. In addition to meeting current VHA requirements, the C&P office's physician files also contained results of checks with the Health and Human Services Medicare exclusionary lists. The PI/QM Program appropriately reported monthly mortality data by ward and time of death through a mechanism established by VISN 5 in FY 1999, and performed follow-up reviews of occurrence rates outside the VISN's established boundaries.

Homemaker/Home Health Aide (H/HHA) Program – Clinical and Administrative Procedures Were In Place. Veterans Health Administration (VHA) Directive 98-022 prescribes the implementation of several programs to meet the long-term care needs of veterans. One such activity discussed in this guidance is the H/HHA Program. The program provides homemaker and home health aide visits to eligible patients in their homes and communities using contract nursing home funds. VA medical facilities are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of treatments and costs. Expenditures for patients receiving home health aide services

cannot exceed 65 percent of the average nursing home per diem rates. This program is consistent with the *Veterans Millennium Health Care and Benefits Act*, Public Law 106-117, which promotes the provision of non-institutionalized health care in community settings.

We interviewed key DCVAMC employees, reviewed the contracts of 5 Community Health Agencies (CHA), assessed 10 H/HHA patients' records, and interviewed 5 patients to determine the effectiveness of controls over the H/HHA Program. Program managers had an appropriate number of employees to manage the program. There was a designated coordinator, a director, and an oversight committee assuring responsible fund management and patient care. The five CHAs utilized by DCVAMC to provide H/HHA services to veterans were licensed by the state and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We spoke to five H/HHA patients or their caretakers to assess patient satisfaction. The patients were very satisfied with the services they received, and believed that the program helped them remain in their homes.

Patients Interviewed Were Generally Satisfied With the Quality Of Care. We interviewed 22 inpatients and 35 outpatients during our visit. All patients rated the quality of care they received as good to excellent.

Pharmacy Security Was Appropriate. The DCVAMC pharmacy had appropriate security that included card access at the hallway doors leading into the pharmacy area and vaults containing controlled substances. Panic buttons and closed-circuit television cameras that alert the medical center police were placed at strategic sites for use by pharmacy employees dealing with the public. Pharmacy access was recorded and provided an audit trail of names, dates, and times of individuals entering the area. Pharmacy employees ordered all controlled substances and all deliveries were made directly to the pharmacy.

Opportunities for Improvement

Clinical Services Contracts – Controls Needed to be Strengthened to Avoid Conflicts of Interest and Improve Contract Administration

Conditions Needing Improvement. VISN management needed to ensure that DCVAMC management avoids conflicts of interest with university affiliates during contract negotiations and subsequent oversight monitoring, and that contracting officers comply with Federal contract administration policies and procedures.

Conflict of Interest. Controls needed to be strengthened to ensure that officials developing, soliciting, awarding, and administering clinical services contracts comply with conflict of interest statutes and contract administration procedures. Federal criminal statutes prohibit Government employees from participating personally and substantially

in matters in which the employees, to the employees' knowledge, have financial interests. VHA policy states that if a physician has a faculty appointment and receives any compensation, or is under the direction of the school, the physician has at least an imputed financial interest in VA contracts with the school.

We identified a potential conflict of interest in one of the clinical services contracts with one of the affiliated medical schools. The Chief of Anesthesiology participated in developing the scope of work and contract requirements for an anesthesiology services contract with the affiliate. He was also the Contracting Officer Technical Representative (COTR) for this contract valued at $630,000. The Chief's COTR responsibilities included monitoring the contractor's performance to ensure compliance with the technical requirements of the contract. The Chief was also employed as an Assistant Professor at the affiliated medical school. For the past 6 years his annual salary from this school has been $80,000. We referred this case of potential conflict of interest to the OIG's Office of Investigations for further review.

Contract Administration. Federal Acquisition Regulations (FAR) and Veterans Affairs Acquisition Regulations (VAAR) require contracting officials to establish files containing records of significant actions to include descriptions of services procured, elements of the negotiation process, legal and technical reviews, and fairness and reasonableness of contract prices. We reviewed eight clinical services contracts with an estimated value of $6.8 million. Contracting officers did not always administer contracts according to FAR and VAAR.

VAAR require price negotiation memorandums (PNM) to describe important elements of the contract negotiation process, such as a description of the services being procured, the purpose of the negotiations, and an explanation of how prices were determined. VAAR also require that the contracting officer ask for sufficient cost or price data to determine price reasonableness. Without the cost or price data, VA risks paying excessive amounts for contracted goods and services. In addition, VAAR require field-pricing audits to determine fairness and reasonableness of prices. Field-pricing audits are required of all sole source contracts with values exceeding $500,000. For example:

- PNMs were not prepared for eight clinical services contracts with a combined total value of about $6.8 million. For example, the file for a $1.7 million contract with a vendor to provide medical/surgical and critical care staff nurses to the DCVAMC did not contain the required contract documents. There was no documentation to show how the contract price of $1.7 million was determined. Further, the contract file did not contain required signatures attesting to the presence of contract nurses, nor did it contain required monthly reports of amounts paid for services to the contractor. Without these contract documents, we were unable to determine whether VA was receiving services in accordance with the terms of the contract.

- Cost or price data was not obtained for two contracts with a combined value of $1.1 million. A contract in the amount of $495,000 required the vendor to provide community-based outpatient clinic pharmacy, radiology, and laboratory services.

There was no documentation in the contract file that cost or price data was obtained to determine the fairness and reasonableness of the contract price.

- Facility managers did not request a field-pricing audit to determine the fairness and reasonableness of the proposed price for one contract with a value of $630,000. The contract required the vendor to provide cardiac anesthesiologists to the DCVAMC. There was no documentation in the contract file to support the fairness and reasonableness of the contract price.

FAR and VAAR require that the contract files contain other important contract documents including legal and technical reviews, justifications for using sole source procurements, COTR delegation memorandums, and other important and related documents. The following table summarizes the significant contract administration deficiencies found during our review of the eight contracts:

Deficiencies Found in Eight Contracts

Contract Deficiencies	V688P-2384 $1,700,000	V688P-2385 $1,700,000	V688P-2475 $684,000	V688P-2476 $681,000	V688P-0019 $646,000	V688P-2437 $630,000	V688P-2445 $495,000	V688P-2589 $240,000
[illegible]	X	X	X	X	X	X	X	X
Legal/technical Reviews not performed.	X	X				X		
[illegible]						X	X	
Field pricing audits not performed.						X		
[illegible]							X	
Market Research not conducted.						X	X	
[illegible]	X	X	X	X	X	X	X	X
COTR delegation memorandum not acknowledged by contractor.						X	X	X
[illegible]	X	X	X	X	X	X	X	X
Monthly expense reports not provided to contracting officer by COTR.	X	X	X	X				
[illegible]	X	X	X	X	X	X	X	X
VA Form 1358 to obligate contract funds not prepared.							X	
[illegible]	X	X	X	X	X	X	X	X
Copies of scarce medical services contracts not submitted to Director, Medical Sharing Office.					X	X		X
[illegible]	X	X	X	X				

The significant number of contract documentation deficiencies demonstrated the need for immediate attention to ensure that contracts are administered in accordance with FAR and VAAR. It should be noted that contract V688P-2437 for $630,000 in the above table

is the contract wherein a potential conflict of interest existed with the affiliated medical school.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the DCVAMC Director implement controls to: (a) prevent potential conflicts of interest, and (b) administer contracts in accordance with FAR and VAAR.

The VISN and DCVAMC Directors agreed with the findings and recommendations, and reported that effective August 2, 2002, the conflict of interest in Anesthesiology Service had been resolved, and that contracting services will follow FAR and VAAR policies and procedures.

The VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans. We will follow up on planned actions for contracting services until they are completed.

Government Purchase Card Program – Controls Needed to be Strengthened

Conditions Needing Improvement. VISN management needed to ensure that Government Purchase Card Program controls are strengthened in the following areas:

- Competition is promoted to the maximum extent practicable for orders that exceed $2,500.
- Purchase cardholders are properly trained.
- Charges to purchase cardholder accounts are verified.
- Purchase cards are timely cancelled.
- Supporting documentation for purchases is retained.
- Purchase cards are used appropriately.
- Quarterly joint reviews are conducted.
- Duties of program officials are properly segregated.
- Local purchase card policy is finalized and issued.

VA facilities are required to use Government purchase cards for small purchases of goods and services (usually $2,500 or less). FAR also permit the Government to use purchase cards for the acquisition of supplies and services, the aggregate amount of which does not exceed $100,000. The Purchase Card Program at the DCVAMC had 86 purchase cardholders and 31 approving officials, as of July 10, 2002. Cardholders processed 23,458 transactions totaling approximately $15.7 million between October 1, 2000, and May 31, 2002.

Competition. FAR require purchase cardholders to promote competition to the maximum extent practicable in order to obtain supplies and services from the sources whose offers are most favorable to the Government. For the 20-month period ending May 31, 2002, acquisition personnel, including two purchase cardholders, placed 45 orders totaling

approximately $265,970 for hip and knee implants and accompanying components without soliciting competition. Data obtained from the National Acquisition Center showed that Federal Supply Schedule (FSS) vendors offered comparable items at lower prices. In February and October 2001, for example, cardholders purchased hip and knee implants with accompanying components on the open market for $10,751 and $6,613, respectively. The prices for comparable prosthetic hip and knee implants and accompanying components from a FSS vendor would have been $6,534 and $4,070, respectively. As a result, VA paid $4,217 (64.5 percent) more on the open market for each hip implant and $2,543 (62.5 percent) more for each knee implant. If the cardholders had used FSS vendors for the 45 orders, the facility could have saved approximately $162,177 ($265,970/1.64).

Cardholder Training. FAR require that employees making purchases above the micro-purchase level of $2,500 have warrants with single-purchase dollar limitations. Cardholders receive warrant authority based on the completion of a 40-hour training course on simplified acquisition procedures. Warrants were issued to 8 of 16 cardholders with single-purchase limits greater than $2,500 without completing the required 40-hour training. One of the 8 cardholders made 22 purchases ranging from $2,557 to $7,598. The acting purchase card coordinator reduced the 8 untrained cardholders' single purchase limits to $2,500 during the CAP.

Verification of Charges. FAR require purchasing agents to verify the accuracy of charges to their accounts, and to dispute erroneous charges. For the 12-month period ending December 31, 2001, 2 purchase cardholders placed 20 orders to 2 vendors totaling $359,518 for defibrillators and accompanying components. In 3 of the 20 orders, a cardholder and approving official did not ensure that prices charged for defibrillators were accurate and consistent with FSS contract prices. As a result, the DCVAMC overpaid the vendor $13,428. In response to our inquiry, the vendor's regional sales representative reviewed the matter and agreed to issue a credit to the facility for $13,428.

Cancellation of Credit Cards. Purchase cards were not cancelled promptly when cardholders separated from VA service. The acting purchase card coordinator was frequently unaware that cardholders had left VA because the facility did not require cardholders to clear with the coordinator during clearance procedures. We identified 8 cardholders who left VA between January 12, 2001, and April 20, 2002, whose cards remained active up to 13 months after separation. Although no purchases were made using the cards, VA could have incurred expenses associated with unauthorized use.

Questionable Purchases. Cardholders were not always retaining appropriate supporting documentation, such as packing slips, invoices, and sales slips to support transactions. Cardholders were unable to provide supporting documentation for 14 (23 percent) of 60 purchase card transactions in our sample of transactions. The 14 transactions totaled approximately $18,000, including charges of $809 from a restaurant and $443 for photographic supplies. The appropriateness of such purchases is questionable without supporting documentation providing independent evidence of descriptions, quantities, and unit prices.

Approving officials, as well as the purchase card coordinator, needed to review documentation during the certification and oversight processes to ensure that supplies and services were authorized and appropriate for VA business. VA policy requires that supporting documentation be retained in inactive storage for 1 year after the close of the fiscal year, and 6 years and 3 months after the period covered by the account.

Use of Purchase Cards. Cardholders inappropriately used purchase cards for printing services and General Services Administration (GSA) vehicle maintenance. Cardholders obtained printing services from a local vendor rather than from the Government Printing Office (GPO). Cardholders must use the GPO unless they obtain written waivers from the Joint Committee on Printing or GPO. Cardholders placed 18 orders for printing services, valued at approximately $23,000, with a local vendor without obtaining the required waivers. On another occasion, $340 was billed to a purchase card rather than the Government Fleet Card for maintenance on two GSA vehicles used by the Security Service.

Quarterly Joint Reviews. DCVAMC managers did not conduct quarterly joint reviews of cardholders and approving officials as required by VHA policy. The facility did conduct monthly audits of cardholder accounts using the statistical sampling of purchases provided by the Financial Service Center. However, VHA policy requires quarterly joint reviews of all cardholder accounts not reviewed in the statistical sampling of cardholder purchases.

Segregation of Duties. VA policy requires different individuals to hold the positions of purchase card coordinator and dispute officer. A basic internal control standard requires the segregation of duties to reduce the risk of error or fraud. We found that the acting purchase card coordinator also served as the dispute officer. Management indicated that different individuals will hold the positions of acting purchase card coordinator and dispute officer.

Local Purchase Card Policy. Management had not finalized its local Purchase Card Policy. At the time of our review, the draft policy did not include a section on inappropriate use of the card and a list of items that may not be procured using the card, such as telecommunication services, fuel, non-GPO printing, and maintenance for GSA vehicles. In addition, the draft policy did not specify that three different employees should hold the positions of purchase card coordinator, dispute official, and billing office official.

Recommended Improvement Action 2. We recommended that the VISN Director require the DCVAMC Director to ensure that: (a) purchasing agents obtain supplies and services from FSS vendors or seek competition to the maximum extent practicable; (b) cardholders are trained appropriately; (c) cardholders and approving officials verify the accuracy of charges and dispute erroneous charges; (d) unneeded purchase cards are canceled timely; (e) supporting documents for purchase card transactions are retained; (f) inappropriate use of purchase cards is eliminated; (g) quarterly joint reviews of

cardholders and approving officials are conducted; (h) different individuals hold the positions of acting purchase card coordinator and dispute official; and (i) a Purchase Card Program policy is issued.

The VISN and DCVAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Accounts Receivable – Billing and Collection Needed Improvement

Conditions Needing Improvement. VISN management needed to ensure that Medical Care Collection Fund (MCCF) staff improve efforts to bill third-party insurers in a timely manner. Management needed to ensure that the non-benefit debts of former employees are collected in a timely manner.

Billing for Inpatient Episodes of Care. Title 38, United States Code authorizes VA to collect from insurers to offset the cost of providing medical care for non-service connected conditions. We reviewed 56 unbilled inpatient episodes of care for the period October 1, 2001 through May 31, 2002. We asked MCCF staff to review the unbilled inpatient report to determine if insurance carriers could be billed. The review showed that 16 inpatient episodes were not billable because treatments were for service-connected conditions or not covered by patients' insurance policies. As a result of our inquiry, the remaining 40 episodes of care (71 percent) were billed to insurers for a total of $ 1.1 million. Of the 40 inpatient episodes billed to insurers, 31 inpatient episodes (78 percent) were billed between 1 and 3 months from the dates of discharges. However, 9 inpatient episodes (23 percent), valued at $232,755, were not billed until 4 to 6 months after the discharge dates. By applying the DCVAMC's 25.8-percent collection rate for billable care to the billable amount of $232,755 for these 9 inpatient episodes, we estimated that MCCF staff could have collected $60,051 ($232,755 x 25.8 percent) more timely.

The MCCF Coordinator stated that the backlog of unbilled inpatient episodes of care resulted from patients refusing to provide their insurance information upon admission, or the patients not being medically fit to provide the insurance information at the time of admission. MCCF staff stated that in these cases they used telephone contacts, letters, and social workers to obtain the insurance data from the patients. The MCCF Coordinator stated that the unbilled inpatient report will be run weekly so that insurance data will be obtained more promptly and billing will be more timely.

Former Employee Debts. We reviewed 2 former employees' debts valued at $1,344, and 2 current employees' debts valued at $6,219, to determine if adequate follow-up had been made after the employees received the third demand letters. The two former employees' debts were established in March 2001 and January 2002. We found that the two former

employees' debts were not followed up after the third demand letters and had not been forwarded for Internal Revenue Service (IRS) offset. The Financial Manager stated that he would forward the two former employees' debts for IRS offset. He also stated that he would improve follow-up on former employees' debts after the third demand letters.

Recommended Improvement Action 3. We recommended that the VISN Director require the DCVAMC Director to improve collection efforts by: (a) timely billing for inpatient episodes of care, and (b) aggressively pursuing former employees' debts.

The VISN and DCVAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Controlled Substances – Inspection Procedures Needed to be Improved

Conditions Needing Improvement. VISN management needed to ensure that controlled substances inspections are conducted appropriately. VHA policy requires an adequate and comprehensive system to include safety and control for all Schedule II-V controlled substances. Controls needed to be strengthened in the following areas:

- Pharmacy inventory was not computerized. Drug accountability software had not been installed at the DCVAMC.

- Monthly, unannounced inspections conducted during the 12-month period from June 2001 through May 2002, were not always complete. During four monthly inspections, an inspector failed to inspect one of the assigned inventory areas.

- Controlled substances held for destruction were not stored in properly sealed containers and inventoried monthly.

- Inspectors were assigned to conduct 12 inspections in a year, while VA policy states that no single inspector will perform more than 6 monthly inspections in a 12-month period.

- Inspectors' reports did not always contain sufficient information to identify inspection discrepancies. In some cases, the reports did not identify the specific problems. For example, on one report only the drug name was listed. The identifying number on VA Form 10-2638, Controlled Substance Administration Record (commonly known as the Green Sheet) was not provided. This made it difficult for nursing and pharmacy employees to trace the drug and unclear as to the quantity of missing drugs. A standardized report was needed to ensure appropriate reporting.

- The Controlled Substances Inspection Coordinator did not take a proactive role in the process of resolving inspection discrepancies. The coordinator had no documentation of follow-up on controlled substances missing at the times of inspections. Additionally, inspection results were not tracked and trended to identify potential problem areas for improvement.

Recommended Improvement Action 4. We recommended that the VISN Director require the DCVAMC Director to: (a) correct each deficiency described above, and (b) establish monitors to ensure inspection procedures of controlled substances are improved.

The VISN and DCVAMC Directors agreed with the findings and recommendations, and reported that on September 2, 2002, Pharmacy Service implemented a computerized inventory system for controlled substances, inspection forms have been revised, and inspectors retrained. In addition, Pharmacy Service practices for destruction and inventory procedures were changed on August 2, 2002. The DCVAMC Director provided acceptable improvement plans for the assignment of inspectors during annual inspections, identification of discrepancies, and tracking and trending of inspection results. We will follow up on planned actions until they are completed.

Vendor Representative Visits – Controls Needed to be Strengthened

Conditions Needing Improvement. VISN management needed to ensure that visits by vendor representatives are controlled in accordance with a unified local policy and that employee acceptance of gifts from vendors is monitored.

Vendor Representative Visits. DCVAMC management did not have a comprehensive policy covering vendor representative visits to the facility. As a result, DCVAMC's services had either developed their own policies or did not have policies for vendor representative visits. For example, the Pharmacy Service had a policy requiring vendor representatives to schedule appointments through administrative personnel. The Medical Service also had a policy covering vendor representative visits but its policy did not require appointments. Indeed, the Medical Service policy, Guidelines for Pharmaceutical Representatives, effectively encouraged vendor representative visits without appointments by stating: "Ideal venues for interactions with physicians include the house staff lounge and the Medical Service conference room *before or after* scheduled conferences...." The Mental Health Service did not have a written policy covering vendor representative visits, although the Administrative Assistant, Mental Health Service asserted that vendor representatives were not permitted to visit the Mental Health Service staff without appointments. DCVAMC managers had drafted a new policy that required vendors to sign in with the DCVAMC police and wear identification badges while visiting the medical center. However, the new policy left the development and implementation of policies and procedures governing visiting vendors to each service. As discussed above, these policies and procedures either varied from one service to another or were absent altogether, resulting in uncertainty for vendor representatives and

weakening of management controls. The Administrative Officer, Medical Service confirmed that vendor representatives frequently visited physicians without appointments.

Employee Acceptance of Gratuities. VA policy restricts employee acceptance of gifts. Employees may accept gifts having a market value of $20 or less per source per occasion, provided the aggregate market value of individual gifts received from any one person or vendor does not exceed $50 in a calendar year. Vendors frequently provided meals for staff physicians and residents. We were not able to determine if the value of these meals exceeded the established limits because there was no documentation pertaining to the value or frequency of these meals. Vendors often provided promotional items to DCVAMC employees, but these were of inconsequential value, consisting mainly of items such as pens and note pads. The Pharmacy Service policy prohibited the distribution of free pharmaceutical samples, while the Medical Service policy did not address this issue and the Mental Health Service had no related policy. We did not find any evidence that free samples had been distributed.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the DCVAMC Director: (a) develop and enforce policy related to vendor representative visits by centralizing the appointment process to ensure that all visits are by appointment only and appropriately documented, and (b) request that Regional Counsel review the practice of pharmaceutical vendors providing meals to determine if they are in compliance with VA policy.

The VISN and DCVAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are completed.

Supply Inventory Management – Excess Inventories Needed to be Reduced and Controls Needed to be Improved

Conditions Needing Improvement. VISN and DCVAMC management needed to ensure that Acquisition and Materiel Management Service (A&MMS) employees effectively use the Generic Inventory Package (GIP) to manage and control three primary inventories: Office Supplies; Supply Processing and Distribution (SPD) containing medical supplies, such as catheters and bandages; and a Supply Fund warehouse containing medical equipment, such as wheelchairs and housekeeping supplies, such as paper towels and cleaning supplies.

VHA guidelines require the use of the GIP, VA's automated inventory management system, to manage and control supply inventories. GIP data must be accurate for the program's automated management features to identify excesses and shortages. Inventories should not exceed 30-day supplies. During the 1-year period from June 1, 2001 through May 31, 2002, the DCVAMC spent approximately $5.1 million on the

three primary inventories. As of May 31, 2002, the value of the Supply Fund warehouse and Office Supplies inventories were $268,334 and $99,165 respectively. The value of the SPD inventory was unknown due to inaccurate data.

Inaccurate SPD Data. Management acknowledged that the SPD inventory was inaccurate for more than 18 months. Consequently, employees were not using the GIP during the processing and distribution of supplies to correct and update the data. During the weekend prior to our visit, employees conducted an SPD wall-to-wall inventory. During the week of our visit, they were entering this data into GIP. Management indicated that A&MMS staff would receive additional GIP training in timely and accurately recording inventory receipts and disbursements of supply and equipment items.

Excess Stock. We assessed the stock levels for the Office Supplies and Supply Fund warehouse inventories recorded in the GIP, as of May 31, 2002. We found that 44 percent of the supply items on hand exceeded the required 30-day stock levels and the value of the combined excess stock was $161,412. The value of excess stock in the Office Supply inventory totaled $83,137. The value of excess stock in the Supply Fund warehouse inventory totaled $78,275. With regard to the excess stock of office supplies, we estimated that $29,000 of the $83,137 excess stock involved photocopy paper. Managers told us the paper was purchased by the truckload to take advantage of discount pricing and due to space limitations at the DCVAMC warehouse, the paper was stored at the VAMC Perry Point, Maryland warehouse. When the DCVAMC needed copy paper, VAMC Perry Point shipped the paper to VAMC Baltimore and a truck was driven round trip from Washington to Baltimore for pick up.

Inventory records were not kept of the copy paper stored at Perry Point. Additionally, a cost-benefit analysis was not conducted to ascertain whether buying and storing paper by the truckload made economic sense.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the DCVAMC Director implement controls to: (a) monitor inventory levels and reduce line items to maximum 30-day supplies; (b) provide additional GIP training to A&MMS staff with an emphasis on timely and accurately recording inventory receipts and disbursements of supply and equipment items; (c) perform a wall-to-wall inventory of the Office Supplies inventory at all locations and adjust GIP records accordingly; and (d) conduct a cost-benefit analysis to justify purchasing copy paper by the truckload and storing it offsite at VAMC Perry Point.

The VISN and DCVAMC Directors agreed and reported that training had been provided to A&MMS employees on the effective use of the GIP for managing office supplies, as well as medical supplies and equipment. Additionally, a cost-benefit analysis will be conducted prior to future bulk purchases of copier paper. The DCVAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are completed.

Report Of Survey Program – Controls Needed to be Improved

Condition Needing Improvement. VISN and DCVAMC management needed to ensure that the loss, damage, or destruction of Government property be reported in accordance with the Report of Survey Program as required.

VA policy requires supervisors to formalize findings related to the loss, damage, or destruction of Government property on Report of Survey forms. We reviewed the VA Police Uniform Crime Reports for the period October 2000 through June 2002. The reports showed that there were 93 instances of theft of Government property with a combined value of $43,500. The stolen items, which included laptop computers, hard drives, and monitors, had a total value of approximately $16,000. Although the thefts were reported to DCVAMC Police as required, DCVAMC supervisors initiated only one Report of Survey for a theft of cash totaling $80 from the DCVAMC Police evidence storage room.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the DCVAMC Director: (a) prepare Reports of Surveys for the 92 reported thefts of Government property for which reports of surveys were not initiated, and (b) provide refresher training to DCVAMC supervisors on their responsibilities in preparing Report of Survey forms for the loss, damage, or destruction of Government property.

The VISN and DCVAMC Directors agreed with the findings and recommendations. The VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans. Reports of Surveys were completed on each of the 92 reported Government property thefts. Report of Survey training was scheduled on a quarterly basis and was first conducted in May 2003. We will follow up on planned actions until they are completed.

Automated Information Systems – Enhanced Security Awareness Training was Needed

Condition Needing Improvement. VISN management needed to ensure that all DCVAMC employees receive annual computer security awareness training. Security awareness training includes the basics of computer security and addresses the need to protect information from vulnerabilities to known threats. The training also covers all aspects of contingency planning, including emergency response plans, backup plans, and recovery plans.

We reviewed the training report for Information Security Awareness Training for the period October 1, 2001 to July 15, 2002. We found that 636 (31 percent) of the 2,037 DCVAMC employees had not taken the annual computer security training. The Information Security Officer will monitor the training report periodically to ensure that DCVAMC staff complete the annual security training.

Suggested Improvement Action. We suggested that the VISN Director ensure that the DCVAMC Director: (a) implement controls to monitor security training, and (b) provide required annual security training to all DCVAMC employees.

The VISN and DCVAMC Directors agreed with the findings and suggestions, and the VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans.

Timekeeper Desk Audits – Timekeeper Monitoring Needed to be Strengthened

Condition Needing Improvement. VISN management needed to ensure that semi-annual desk audits of part-time physician timekeepers are conducted. The Employee Accounts Section had the authority and responsibility to perform periodic desk audits of all timekeepers on a semi-annual basis with respect to the preparation and maintenance of time and attendance reports, handled by unit timekeepers.

We reviewed the desk audits of the timekeepers responsible for keeping time and attendance for part-time physicians. The Employee Accounts Section did not conduct desk audits for these timekeepers in FYs 2000 and 2001. The last desk audits were conducted in FY 1999. The Employee Accounts Section was in the process of conducting desk audits for FY 2002.

Suggested Improvement Action. We suggested that the VISN Director ensure that the DCVAMC Director enforce the requirement for the Employee Accounts Section to conduct semi-annual desk audits of part-time physician timekeepers.

The VISN and DCVAMC Directors agreed with the findings and suggestion, and the VISN Director concurred with the DCVAMC Director's corrective action plan. The DCVAMC Director provided acceptable improvement plans.

Environment of Care – Sanitation Infection Control Procedures, and Other Environmental Areas Needed to be Improved

Conditions Needing Improvement. Our inspection of the VAMC found the following environment of care deficiencies that needed to be addressed:

Patient Safety. The short distance from the toilet to the door in a bathroom (room 3B100) prevented the door from fully opening, thereby obstructing entry of staff should a patient require assistance.

The Environment of Care Committee meeting minutes noted that in preparation for the JCAHO inspection, the facility conducted a mock survey in April 2002. The surveyor found that sanitation in patient care areas needed improvement. Management had been active in improving sanitation. The Chief of Facilities Management Service provided a list of initiatives that were implemented to improve cleanliness in the medical center. They included approval from the Medical Center Director to hire 30 more housekeepers and a budget to contract with a private agency for additional housekeeping services. Medical center monitors showed a steady improvement in cleanliness.

Suggested Improvement Action. We suggested that the VISN Director encourage the DCVAMC Director to continue to support the ongoing efforts to improve the cleanliness of the medical center.

The VISN and DCVAMC Directors concurred with our findings and suggestion and reported that the deficiencies have been remedied. We consider these issues closed.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the Washington, DC VA Medical Center.

Report Number: 02-02443

Recommendation	Explanation of Benefits	Better use of funds
2a	Promoting competition to the maximum extent practicable.	$162,177
2b	Verifying accuracy of charges and disputing erroneous charges.	13,428
3a	Timely billing of inpatient episodes of care.	60,051
	Total	$235,656

VISN 5 Director Comments

Response to OIG CAP Review
Washington, DC VA Medical Center
July 15 – 19, 2002

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the DCVAMC Director implement controls to: (a) prevent potential conflicts of interest, and (b) administer contracts in accordance with FAR and VAAR.

Conflict of Interest-Anesthesia Contract has Chief of Anesthesiology as COTR.
Chief of Anesthesiology is also on the faculty of the affiliate
Concur-Yes
Action Plan-Chief of Anesthesiology has been replaced by a fee-based anesthesiologist as COTR who has no affiliation with the medical school effective 8/02.

Contract Administration-Contracting Officers did not always administer contracts according to FAR and VAAR policies and procedures

Concur-Yes
Action Plan-Develop and implement contract checklist effective 8/02. (Attachment 1)

Recommended Improvement Action 2. We recommend that the VISN Director require the DCVAMC Director to ensure that: (a) purchasing agents obtain supplies and services from FSS vendors or seek competition to the maximum extent practicable; (b) cardholders are trained appropriately; (c) cardholders and approving officials verify the accuracy of charges and dispute erroneous charges; (d) unneeded purchase cards are canceled timely; (e) supporting documentation for purchase card transactions are retained; (f) inappropriate use of purchase cards are eliminated; (g) quarterly joint reviews of cardholder and approving officials are conducted; (h) different individuals hold the positions of acting purchase card coordinator and dispute official; and (i) a Purchase Card Program policy memorandum is issued.

Competition-Joint replacements purchased without using FSS vendors
Concur-Yes
Action Plan-August, 2002 Purchasing agents have been trained to seek supplies and services from GSA or FSS vendors first. This has been reinforced to the purchasing agents.

Cardholder Training-Cardholders not receiving required training
Concur-Yes
Action Plan-Vacant Purchase Card Coordinator position filled October 2002. Purchase card training conducted in the second quarter FY 2003 covering all aspects of the use and management of the purchase card. See attached list for detail.

Verification of Charges-Purchasing agents not verifying accuracy of charges

Concur-Yes
Action Plan-In compliance with Government Wide Purchase Card Program Medical Center Policy 90-16, the Purchase Card Coordinator is reviewing the verification procedure with cardholders and approving officials in all training classes.

Cancellation of Credit Cards-Purchase cards not cancelled promptly when cardholders are separated from VA Service
Concur-Yes
Action Plan-Employee Clearance Policy 09-28 has been revised effective October 2002 and return of credit cards has been placed on the checkout list at the time of out-processing for separated employees (see Attachment 2).

Questionable Purchases-Cardholders not retaining appropriate supporting documentation
Concur-Yes
Action Plan-In compliance with Medical Center Policy 90-16, the Purchase Card Coordinator has included in training of cardholders and approving officials information regarding the retention of all purchase card transaction supporting documentation as mandated in VHA Handbook 1730.1 dated 6/14/02.

Use of Purchase Card-Cardholders inappropriate use of purchase cards for printing services and vehicle maintenance
Concur-Yes
Action Plan- In compliance with Medical Center Policy 90-16, the Purchase Card Coordinator has included in training of cardholders and approving officials information regarding the appropriate use of purchase cards as mandated in VHA Handbook 1730.1 dated 6/14/02.

Quarterly Joint reviews-not currently conducted
Concur-Yes
Action Plan-To date, seven audits have been completed. These joint audits of the purchase cardholder and approving officials covered verification of charges, security of cards, documentation and appropriate use of cards. All audits have been forwarded to the Associate Medical Center Director for final review and approval of recommendations.

Segregation of Duties-Management indicated that different individuals would hold the positions of acting purchase card coordinator and dispute officer

Concur-Yes
Action Plan-The following duties have been defined and designated:
Billing Officer-Kaiser Braham, Assistant Director AMM&S Service Line
Disputes Officer-Steve Robinson, Assistant Chief AMM&S Service Line
Alternate Disputes Officer-Jeanette Fuller, Purchase Card Program Coordinator

Local Purchase Card Policy-Local purchase card policy not finalized
Concur-Yes
Action Plan-Government Wide Purchase Card Program Policy 90-16 Policy was approved and implemented October, 2002 (Attachment 3).

Recommended Improvement Action 3. We recommend that the VISN Director require the DCVAMC Director to improve collection efforts by: (a) timely billing inpatient episodes of care, and (b) aggressively pursuing former employee debts.

Billing for Inpatient Episodes of Care-Inpatient billing not timely

Concur-Yes
Action Plan-Inpatient cases are currently being coded and billed within <30 days of discharge. The Medical Center Director is monitoring billing weekly.

Former Employee Debts-Lack of timely follow up
Concur-Yes
Action Plan-The Chief, Fiscal Services resolved the 2 cases identified immediately and is currently monitoring more timely follow up of employee indebtedness to the federal government.

Action Plan-Medical Center Policy 11-18 Inspection of Controlled Substances and Alcohol monthly inspection forms have been revised and inspector retraining completed (Attachment 4).

Recommended Improvement Action 4. We recommend that the VISN Director require the DCVAMC Director to: (a) correct each deficiency described above, and (b) establish monitors to ensure inspection procedures of controlled substances are improved.

Inventory not accurate
Concur-Yes
Action Plan- Pharmacy implemented computerized inventory software effective September 2002.

Incomplete monthly inspections
Concur-Yes
Action Plan-Medical Center Policy 11-18 Inspection of Controlled Substances and Alcohol monthly inspection forms have been revised and inspector retraining completed (Attachment 4).

Controlled substances held for destruction not stored properly or inventoried
Concur-Yes
Action Plan-Practice for controlled substance destruction and inventory procedure changed effective 8/2002 (Attachment 5).

Inspectors not assigned properly
Concur-Yes
Action Plan-Inspectors assigned to perform 6 monthly inspections annually per VA policy (Attachment 6).

Discrepancy Resolution
Concur-Yes
Action Plan-Standardized report implemented (Attachment 7). Inspection Coordinator tracking and trending discrepancies by unit.

Controlled Substances Monitoring
Concur-Yes
Action Plan-Monitor inspection procedures monthly

Recommended Improvement Action 5. We recommend that the VISN Director ensures that the DCVAMC Director: (a) develop and enforce DCVAMC policy related to vendor representative visits by centralizing the appointment process to ensure that all visits are by appointment only and appropriately documented, and (b) request that Regional Counsel review the practice of pharmaceutical vendors providing meals to determine if they are in compliance with VA policy.

Vendor Representative Visits-No comprehensive policy
Concur-Yes
Action Plan-Medical Center Policy 07-13, Identification and Standards Governing Contractors and Vendors developed and reviewed by Regional Counsel and implemented October, 2002 (Attachment 8).

Employee Acceptance of Gratuities-Vendors providing meals for staff physicians and residents
Concur-Yes
Action Plan- Medical Center Policy 07-13, Identification and Standards Governing Contractors and Vendors developed and reviewed by Regional Counsel and implemented October, 2002 (Attachment 8).

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the DCVAMC Director implement controls to: (a) monitor inventory levels and reduce line items to a 30-day maximum level; (b) provide additional GIP training to A&MMS staff with an emphasis on timely and accurately recording inventory receipts and disbursements of supply and equipment items; (c) perform a wall-to-wall inventory of the Office Supplies inventory at all locations and adjust GIP records accordingly; and (d) conduct a cost-benefit analysis to justify purchasing copy paper by the truckload and storage offsite at VAMC Perry Point.

Inaccurate SPD Data
Concur-Yes
Action Plan-The Assistant Chief AMM&S has been assigned to train all PPM staff in all aspects of the General Inventory Package (GIP) program. Bar-coding equipment will also be replaced to increase efficiency and effective use of the GIP program. SPD inventory placed on GIP August 2002.

Excess Stock
Concur-Yes
Action Plan-The Chief Personal Property Management Section (90B) has been directed and has taken action to reduce and maintain a 30-day stock level to the maximum extent possible on all supplies and has set stock limits to meet this criterion. This is an on-going process (stock reduction-elimination of slow moving items), which requires a continuous review of all stock. To improve inventory accuracy rates, weekly spot inventories are taken with wall-to-wall items. See attached inventory statistics (Attachment 9). The office supply inventory will be included and inventoried beginning February 2003 and tracked. A cost benefit analysis will be conducted prior to the next bulk purchase of copier paper and off-site storage at our Perry Point facility.

Assistant Chief of AMM&S will conduct quarterly supervisor training on the Report of Survey program beginning February 2003.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the DCVAMC Director: (a) prepare Report of Survey forms for the 92 reported thefts of Government property, and (b) provide refresher training to DCVAMC supervisors on their responsibilities in preparing Report of Survey forms for the loss, damage, or destruction of Government property.

Report of Surveys not being completed or tracked per VA policy
Concur-Yes
Action Plan-Prepare Report of Survey for the 92 reported thefts to be completed by the end of February 2003.

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the DCVAMC Director: (a) implement controls to monitor security training reports, and (b) provide required annual security training to all DCVAMC employees.

Annual computer security awareness training at 31%
Concur-Yes
Action Plan-Security training will be monitored quarterly by the information security officer. Annual compliance for computer security awareness training level is 100% effective 9/02.

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the DCVAMC Director enforce the requirement for the Employee Accounts Section to conduct semi-annual desk audits of part-time physician timekeepers.

Semi-annual desk audits not conducted
Concur-Yes
Action Plan-Effective January 2003, Medical Center Policy: Time and Attendance for Part-Time Physicians, Dentists and Podiatrists includes monthly monitoring activities by the Service Chiefs of a minimum sample of 5% of the part-time physicians. Semiannual desk audits will be conducted per Time and Attendance policy 09-02 (Attachment 10 & 13).

Suggested Improvement Action 3. We suggest that the VISN Director advise the Medical Center Director to continue to support the overall cleanliness and safety throughout the facility and that managers monitor compliance of infection control procedures in the OR.

Storage and Maintenance of Equipment-Excess equipment in room 4E139
Concur-Yes
Action Plan-Equipment removed

Patient safety-toilet in bathroom too close to the door
Concur-Yes
Action Plan-stall will be removed

Sanitation and Infection Control-OR Employee Lounge
Concur-Yes
Action Plan-Area will be inspected daily by the OR Nurse Manager for cleanliness. Larger trashcans with lids ordered and installed.

Sanitation and Infection Control-Patient food in medication refrigerator
Concur-Yes
Action Plan-Items removed. The Medical Center has a comprehensive environmental surveillance program and administrative rounds program to identify and resolve issues in a timely manner (Attachment 11 & 12).

Sanitation and Infection Control-Water stains on select ceiling tiles
Concur-Yes
Action Plan-Tiles replaced

Signage
Concur- Yes
Action Plan- Sign for Stair #1 at 1st floor level installed 11/18/02.

Suggested Improvement Action 4. We suggest that the VISN Director ensure that the DCVAMC Director use this data in conjunction with their own assessments to focus on areas warranting management attention.

Appendix C

Report Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Chief of Staff to the Under Secretary for Health (10B)
Under Secretary for Health (105E)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Assistant Secretary for Human Resources and Administration (006)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Director, Management and Financial Reports Service (047GB2)
Medical Inspector (10MI)
Deputy Under Secretary for Health for Operations and Management (10N)
Veterans Integrated Service Network Director (10N5)
Director, Washington, DC VA Medical Center (688/00)

Non-VA Distribution

Office of Management and Budget
U.S. General Accounting Office
Delegate Eleanor Holmes Norton
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, United States Senate
- Committee on Veterans' Affairs, United States Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives

Appendix C

Subcommittee on National Security, Emerging Threats and International Relations, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight & Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

This report will be available in the near future on the VA Office of Inspector General Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.